Office of Health Care Quality

Resident Specific Level of Care Waiver Application

10.07.14.22 (Use one form for each resident requiring a waiver)

Name of Assisted Living Manager(ALM) _____

ALM's Phone Number _____

Name of Assisted Living Program _____

Program's Address _____

_____

Census _____ Licensed Capacity _____ Level of Care _____

Number of resident-specific waivers in effect: _____

I am currently: (check if applicable)

☐ Authorized to provide a level of care beyond current licensure

☐ Authorized to provide the level of services described in 10.07.14.22I

This is to request a resident-specific level of care waiver in accordance with **COMAR 10.07.14.22** to permit _____(resident's name) to continue to reside in the facility. I certify that the program is capable of and wishes to care for this resident and that in doing so the needs of other residents will not be jeopardized.

I am requesting this waiver, with the consent of the resident's representative, because: (check if applicable)

☐ The level of care required by the resident exceeds the level of care for which the facility has authority to provide. The level of care the resident requires is _____.

☐ The resident requires services described in **COMAR 10.07.14.22I.** List service(s) required:

_____

With this request, submit:

1. A copy of the resident's most recent completed Health Care Practitioner's Physical Assessment**.**
2. A copy of the resident's most recent completed Assisted Living Manager's Assessment.
3. A copy of the resident's current or proposed Service Plan, indicating all services which are, or will be, provided to the resident if the waiver request is approved.
4. If this request involves a stage three or stage four pressure ulcer, a copy of the most recent completed Wound Assessment.

Please:

1. Describe how the program intends to meet the needs of the resident without jeopardizing the needs of other residents.

2. Describe the ability of staff to provide care to the resident and the content and depth of staff training as it pertains to the resident's care.

3. Describe how the program complies with applicable fire and building codes as detailed in **COMAR 10.07.14.46A.** (Describe your program's life safety equipment.)

4. If this waiver request involves the continuation of services to a resident whose needs fall within one of the categories set forth in **COMAR 10.07.14.22I**, describe how the program will comply with the Medicare requirements for home health agencies set forth in 42 CFR §§ 484.18 (plan of care), 484.30 (duties of the nurse), and 484.32 (therapy services).

5. Other comments:

Applicant's Signature | Applicant's Title | Date

Delegating Nurse's Signature | Delegating Nurse's Phone Number